Agency:	**107 Health Care Authority**
Decision Package Code/Title:	**PL-N1 Improve Medication Assisted Therapies**
Budget Period:	**2015-17 Biennial Submittal**
Budget Level:	**PL –Policy Level**

Recommendation Summary Text

The Health Care Authority (HCA) requests $6,163,000 ($1,391,000 GF-State) for the 2015-17 biennium as the result of expanded treatment for Medicaid clients with opioid and alcohol use disorders using buprenorphine and other approved medications.

Package Description

The HCA is proposing changes to expand the ability of qualified physicians who hold a federal waiver to prescribe buprenorphine/ naloxone (Suboxone®) to prescribe to Medicaid clients for moderate to severe opioid use disorder and make the same changes to coverage for other related medications that do not require special training or certification (collectively known as Medication Assisted Therapy). With evidence of appropriate monitoring, treatment would continue for the length of time deemed necessary by the patient and provider with no requirement for treatment in a facility approved by the Department of Social and Health Services (DSHS) or enrollment in a treatment program administered by the DSHS Behavioral Health and Service Integration Administration (BHSIA). This represents an expansion of services requiring additional funds, as the current HCA policy limits prescribing of Medication Assisted Therapy (MAT) to clients in the BHSIA certified treatment programs for a maximum duration of one year.

Substance Use Disorders are chronic remitting and relapsing diseases, and time limited therapy is not successful. Persons with diabetes are not limited to one year of insulin therapy or required to attend daily nutrition classes. The field of addiction medicine supports the idea that while both medication assisted therapy and treatment are useful with opioid use disorders, medication assisted therapy is more effective at reducing use and retaining people in treatment. A strategy that prioritizes medication assisted therapy for opioid use disorder is better aligned with evidence based practice.

Studies demonstrate that treatment with buprenorphine is comparable to methadone in reducing illicit opioid use. At higher fixed doses, retention rates approach those found with methadone maintenance, and for Medicaid patients, there is no evidence of increased total costs or safety problems compared with methadone. It can be prescribed outside of traditional opioid treatment programs which increases the number of access points for treatment and provides patients with additional flexibility in managing their illness. The BHSIA estimates that the number of clients seeking treatment for opioid use disorders far exceeds the availability of treatment slots in methadone programs. The expansion of MAT will provide office based treatment options for clients who can either not find space in a methadone program, or for whom there is no such program available in their area.

Recent studies have also highlighted the underuse of and need for primary care providers to increase their use of established medication therapies for alcohol and opioid use disorders. Improving access to medication assisted therapy for opioid use disorder is also important given what appears to be a transition from the high rates of prescription opioid use in the state to increasing

rates of heroin use. Alcohol use and its consequences remain a significant problem among patients receiving Medicaid, particularly among those patients also suffering from mental health disorders.

Direct Medical Cost
The HCA estimates that the proposed changes to eligibility for MAT will increase the number of utilizers by approximately 55 clients per month and proportionally increase expenditures by $21,000 each month during the ramp-up after policy change. Additional prescriptions for MAT for fee-for-service and managed care Medicaid clients would increase costs by approximately $4 million per year and additional physician costs would increase approximately $2 million per year following full ramp-up over two years and reaching a total treated population around 1,750 clients each month. The number of clients to be treated is self-limiting based on the number of prescribers available (physicians that are authorized to prescribe Suboxone are limited to a maximum of 100 patients) and the volume of clients likely to seek and remain in treatment at any given time.

Net Social Cost
Net social cost which includes, in addition to direct medical costs, crime and incarceration costs, travel costs and benefit offsets associated with school attendance and work-force participation should also be considered. Studies have shown that medical savings elsewhere in the health care system which cannot be directly quantified with available data offset the increased costs associated with longer-term therapy using buprenorphine and other medication assisted therapies.

Questions related to this request should be directed to Christy Vaughn at (360) 725-0468 or at Christy.Vaughn@hca.wa.gov.

Fiscal Detail/Objects of Expenditure

	FY 2016	FY 2017	Total
1. Operating Expenditures:			
Fund 001-1 GF-State	$ 345,000	$ 1,046,000	$ 1,391,000
Fund 001-C GF-Federal Medicaid Title XIX	$ 1,258,000	$ 3,514,000	$ 4,772,000
Total	**$ 1,603,000**	**$ 4,560,000**	**$ 6,163,000**

	FY 2016	FY 2017	Total
2. Staffing:			
Total FTEs	-	-	-

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	FY 2016	FY 2017	Total
3. Objects of Expenditure:			
A - Salaries And Wages	$ -	$ -	$ -
B - Employee Benefits	$ -	$ -	$ -
C - Personal Service Contracts	$ -	$ -	$ -
E - Goods And Services	$ -	$ -	$ -
G - Travel	$ -	$ -	$ -
J - Capital Outlays	$ -	$ -	$ -
N - Grants, Benefits & Client Services	$ 1,603,000	$ 4,560,000	$ 6,163,000
Other (specify) -	$ -	$ -	$ -
Total	**$ 1,603,000**	**$ 4,560,000**	**$ 6,163,000**

	FY 2016	FY 2017	Total
4. Revenue:			
Fund 001-C GF-Federal Medicaid Title XIX	$ 1,258,000	$ 3,514,000	$ 4,772,000
Total	**$ 1,258,000**	**$ 3,514,000**	**$ 4,772,000**

Narrative Justification and Impact Statement

What specific performance outcomes does the agency expect?
The HCA expects an increase in the percentage of Medicaid clients with substance use disorders receiving medication assisted therapy.

Performance Measure Detail
Activity Inventory
H005 HCA National Health Reform
H010 HCA Healthy Options
H011 HCA All Other Clients – Fee for Service – Mandatory Services

Is this decision package essential to implement a strategy identified in the agency's strategic plan?
The mission of the HCA is to provide high quality health care for the state's most vulnerable residents. This request supports the agency's goal to improve the health of Washingtonians.

Does this decision package provide essential support to one or more of the Governor's Results Washington priorities?
This request supports Results Washington Goal 4.1.2, decrease percentage of adults reporting fair or poor health from 15 percent in 2011 to 14 percent in 2017.

What are the other important connections or impacts related to this proposal?
Recent studies have shown that when patients are maintained on buprenorphine their relapse and retention rates are comparable to patients receiving methadone. This, coupled with the fact that almost 80 percent of opioid dependent patients are not receiving treatment and many treatment

centers are at capacity, suggests the need for additional strategies to reduce the costs and health effects related to opioid dependence. With the recent increase in heroin use, rates of new hepatitis C cases are increasing. The increase is largest among young persons injecting drugs. Increasing access to buprenorphine has the potential to shorten the length of time a person uses injection drugs thereby decreasing the associated risks of harm and acquiring hepatitis C. Given the current cost of the new therapies for Hepatitis C (around $ 84,000 per course of therapy) the prevention of 25 cases of hepatitis C has the potential to achieve cost avoidance in excess of the increased expenditure for MAT (there were 63 new cases of Hepatitis C in 2013 and 37 through July 2014).

Other studies have shown that medical savings elsewhere in the health care system which cannot be directly quantified with available data, offset the increased costs associated with longer-term therapy and treatment drugs. Included in these potential offsets are reductions in length of hospital stays for infants born with neonatal abstinence syndrome. Studies show that infants born to mothers taking buprenorphine are shorter by two to three days when compared to infants born to mothers on other opioids.

Although the potential for these cost avoidance opportunities exist, it is not possible to guarantee them, and they are not measurable as a direct consequence of expanded MAT coverage. They are not included in this decision package request as savings attributable directly to the policy change.

The HCA also anticipates an improved quality of life for those seeking treatment due to decreased travel burden. It is not uncommon for clients who find placement in a methadone program to find such placement in a community at great distance from their own. Large amounts of travel time are expended going to and from daily treatment requirements, preventing ability to attend school or participate in the workforce. With expansion of office based buprenorphine treatment options, more clients are expected to be able to find treatment closer to home, improving their potential to become productive citizens while still in recovery.

What alternatives were explored by the agency, and why was this alternative chosen?
The HCA has worked with the DSHS to attempt expansion of methadone treatment programs with minimal success, as it is difficult to find communities willing to accept such treatment programs in their midst. Opioid substitution therapy in the form of methadone programs faces barriers which prevent increasing treatment capacity at either the speed or in the volume required to provide necessary recovery services to the affected population.

The HCA also considered not expanding eligibility for MAT beyond its current criteria (enrollment in a BHSIA certified treatment program with a maximum of one year of treatment) and has found over time that the majority of patients do not achieve abstinence in that time period, and the capacity of treatment programs artificially limits the population who could be helped by this treatment option.

The HCA has chosen this approach represented in this request because there is no other viable way to provide treatment options in the volume necessary to address the current needs of clients seeking or expected to seek treatment for substance use disorders.

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What are the consequences of adopting this package?
The consequence of adopting this package is an increased proportion of clients able to receive treatment for substance use disorders at the time they are seeking treatment.

What is the relationship, if any, to the state capital budget?
None

What changes would be required to existing statutes, rules, or contracts, in to implement the change?
None

Expenditure and Revenue Calculations and Assumptions

Revenue Calculations and Assumptions:
The anticipated federal funds from Medicaid (Title XIX) are reflected in the fiscal detail.

Expenditure Calculations and Assumptions:
The expenditure calculations were based on the following assumptions:

- Average Per User Per Month cost of MAT in fiscal year 2014 is $264.58 after rebates, with an additional $108.77 in medical costs;
- Based on experience piloting the proposed changes in calendar year 2014, expectation is that a net of 55 additional clients would be added to ongoing MAT each month, for a collective total increase in clients receiving treatment of 1,320 by the end of the biennium;
- Additional client volume is 'pro-rated' month by month for ramp up over the first 24 months following the policy change;
- Based on client population currently receiving MAT after the implementation of the Affordable Care Act, 57 percent of clients/costs are assumed to be expansion population eligible for increased federal match, and 43 percent are assumed to be 'traditional Medicaid' receiving 50 percent match.

Which costs, savings, and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?
Distinction between one-time and ongoing costs:
All costs are assumed to be ongoing.

Budget impacts in future biennia:
Actual expenditures from year to year will vary due to utilization. The HCA anticipates having met expected need at the end of the biennium, with no additional ongoing increases in total client volume ratio. Changes to the total caseload will result in corresponding proportional impact to the costs in future biennia.

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